Payment/Delivery Reform Work Group
Wednesday March 21, 2012
8:00am
Meeting Minutes

Attendees: Melinda Thomas, Terri Motta, Craig O'Connor, Plock Block, Al Charbonneau, Don Fruge, Holly Garvey, Bill Hollinshead, David Keller, Al Kurose, Gus Manocchia, Stacey Paterno, Viviane Weissman

I. Call to Order – Dan Meuse welcomed the group at 8:00am. He thanked the host for the meeting space, and requested the members go around the room for introductions.

II. Review of Draft Payment/Delivery Reform Work Group Presentation
   a. Dan Meuse provided an introduction to the presentation – came to agreement of the sense of the workgroup on a number of different reform options. As putting together presentation for Executive Committee, Dan Meuse recognizes the need to take a "didactical" method to refer to Payment/Reform issues and loop back to workgroup comments. Both what is going on now, what are the innovative ideas currently being discussed, what did the workgroup think and what could the government's role be in assisting toward drive toward more rational, sustainable care. Obviously about a lot of coordination of different agencies, different data – potential lever to be used to effect significant change. Report serves as educational source and reference source for the group.
   b. Dan Meuse wanted to recognize large gaps in report – Medicaid, not a whole lot of discussion around Medicaid and what the program has done in the last 6-7 years. This is because the group mainly only focused on duals, and the discussion on Medicaid will take place in the future. Other gap – lack of "currentness" – discussions on ACOs in July, and things change so quickly in this environment, and what we discussed 8 months ago could potentially be very different now. Dan Meuse will attempt to update the report with this lens on – it's a landscape that changes very frequently. With this being said, Dan Meuse asked group members to identify gaps or areas where the discussion has been misconstrued
   c. Dr. Kurose – announcement made recently that Coastal Medical has a shared savings contract w BCBSRI and thinks this is important to include. Goes into "ACO" vs. "aco" – what Coastal is doing w BCBSRI is accountable care, and thinks that this piece belongs in report in some fashion. Large amount of what went into this was BCBSRI idea, and this was a huge collaborative effort. Totally different mindset from capitation, it's all about being proactive and managing the whole care process - incentives are aligned with the health of the patient. Also, page 11, what an ACO would need to look like in RI – Medicare shared savings opportunity **doesn't** require arrangements with hospitals.

Coastal Medical offers a shared savings ACO for Medicare without a formal partnership with hospitals – thinks they can take on accountability for a defined Medicare population.

d. Gus Manocchia – this contract requires that Coastal meet certain target thresholds before they will see any amount of $. Moving away from Fee for Service can't happen in one day, and so Coastal will still be paid under FFS as they transition.
e. David Keller – commenting as pediatrician – there's a place where children will fit in at the end of the report, since they haven't been a part of chronic care management schemes, and it would be easy to mention children at the end under "vulnerable populations". Also – begins the report w the recommendations on page 3, appearing in bold font but they don't have anything to do with the content of the report and final recommendations. (example – recommendation 2- the group doesn't think there should only be one) So please make final recommendations explicit so that take away is the biggest.
f. Al Charbonneau – left with not so warm fuzzy feeling, doesn't like the phrasing that the group didn't coalesce around specific recommendations- weren't asked to do this.
g. Terri Motta – wants to see examples from other states that are trying to create payment delivery reforms – possible include Oregon's example
h. Bill Hollinshead – linking the first 5 bullets on page 3 to final recommendations. Also, success of RIte Care could be included (although, granted, the program is only 10 years old) to capture some of RI's experimentation and success. Also, take the word "pain" out on bottom of page 5.
i. David Keller – how to evaluate? This would be helpful for policymakers to see the pluses and minuses of different methods
j. Dr. Kurose – in response to "what could role of gov't be" - if we all agree that strictly FFS is problematic, would OHIC or other government agencies potentially play a role in mandating that some percentage of reimbursement over time not be FFS? FFS has perverse incentives, and there are many methods to move away from this.
k. Angela Sherwin– OHIC is trying this through their primary care affordability standard
l. Dan Meuse– although report says group didn't coalesce, not exactly true…because there was a continuous dialogue that a traditional FFS model is bad. Doesn't meet need of payment, system. Asked if this was worth including in final recommendation? Whole group agreed that this needs to be explicitly included.
m. Stacey Paterno - take ideas and where ppl think they could actually go – could help prioritize the work of the Exec Committee and "the state" – need to recognize where ppl think the state has the capability to go. Informative to go through "that process"

n. Dan Meuse - Report is very much a point in time, understanding that this report could be revised at any point and needs to be used as a building block.
o. Terri Motta – doesn't have a sense in how the Board could direct/influence the state's payment/delivery reform. Concrete recommendation to
p. Dan Meuse – the Board recognizes their role in being an "actor" in exchange initiatives. One of their principles is to be a catalyst of innovative ideas (purchase of insurance and the healthcare system), and they recognize their role as a partner in government. Now have a 3rd or 4th player in the gov't arena that can assist in ensuring all activities are moving in a similar direction and not pulling the system apart. The Board recognizes this and in discussion w Exec Committee, this will be a point that will be brought up.
q. Dan Meuse acknowledges - The report begs for a section on government – OHIC, Medicaid, opportunities for the Exchange – will try to do this prior to Monday.
r. Gus Manocchia – going from FFS to something that provides value – suggested including the idea of educating providers about what is going down the road. Many providers don't understand what we're talking about, and need to have some way of communicating with providers on ways to change how they operate.
s. David Keller – touches on this in the second concluding thought (page 16).
t. Craig O'Connor - Coordinated Health Planning – dovetails with payment/delivery reform – not sure if all providers are or will be ready to move away from FFS. Delicate balance, and need to include more about Coordinated Health Planning
u. Dan Meuse – employee system is attempting to change things from the individual side, while OHIC is trying to change things from the system side. Report recognizes need for experimental laboratory style environment where different methods can be piloted and tested, while recognizing need to community. Govt's goal should not be to dictate payment reforms, but to encourage and allow for innovation.
v. Stacey Paterno – thinks that one piece that is always missing is the ability to create the scorecard (to evaluate different methods) and to have ways to measure different work, there might be a bit more leverage to move initiatives forward.
w. David Keller – a scorecard allows you to see why initiatives/projects aren't moving forward (and then avoid different
x. Al Charbonneau – talked about experiment in Rochester where they set expectations and established a baseline…this is a tremendous motivator
y. Dan Meuse – is there important information that we want to measure ourselves (state, health system, etc)by? Tricia Leddy is leading charge

on this question – how do we set baseline and how do we measure/monitor this

z. Al Charbonneau – found that many providers don't understand what's driving the premium. One of the things that' missing in a lot of these discussions is connecting activities within practices and system with premium

aa. Vivian Weissman – this discussion of tracking and measurement should be part of the final concluding thoughts. Whole group agreed.

bb. Dr. Kurose – Innovation Challenge – include placeholder to talk about this? Whole group agreed. Also, provider education is a goal for the future. Coastal has a CME program and would implement with a co-sponsor (broader base of support from insurer or state)

cc. Gus Manocchia – premium discussion is right. In general, public doesn't have a clue about how these are created. Want people to understand where the $ goes.

dd. Dan Meuse – thinks that OHIC is starting to engage small businesses in this kind of discussion. "Health insurance literacy" is critical for the public.

ee. Dan Meuse – Medicare value based purchasing section – planning to move it and into an integrated model and include readmission changes along with the value based purchasing section. Will be switching and mentioning it earlier. Another gap – not mentioned a whole lot – OHIC's affordability standard – will include this.

ff. Stacey Paterno- need to distinguish between what will happen versus ideas of what could happen

gg. David Keller – need to make clear why the recommendations in the beginning are different from the concluding thoughts – riding the wave of the current climate

hh. Stacey Paterno – there is a lot facing providers right now, and there needs to be an acknowledgement of that.

III. Public Comment – No additional Comment given

IV. Adjourn